KENTUCKY BOARD OF LICENSURE FOR NURSING HOME ADMINISTRATORS
PO BOX 1360
FRANKFORT KY 40602
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NURSING HOME ADMINISTRATOR APPLICATION
WORK VERIFICATION FORM

Please have your **current** supervisor complete this form and attach it to your application for licensure. If your current supervisor cannot verify your management experience please have the supervisor of the health care system where experience in the four areas required was received complete this form.

NAME OF APPLICANT _____

NAME OF EMPLOYER _____

FACILITY TYPE ___ **Hospital** ___ **Nursing Home** ___ **Personal Care Home** ___ **Assisted Living**

DATES OF EMPLOYMENT **From** ____/____/____ **To** ____/____/____

201 KAR 6:020. Section 1. (3) states that a person must have six (6) months of continuous management experience in a "health care facility" within three (3) years from the date of application. The management experience shall include evidence of responsibility for: personnel management, budget preparation, fiscal management, and public relations.

Detail below the work experience relative to the APPLICANT named above:
(Please type or print)

1. **Personnel Management (include number of individuals supervised):** _____
   _____
   _____
   _____

2. **Budget Preparation:** _____
   _____
   _____
   _____

3. **Fiscal Management:** _____
   _____
   _____
   _____

4. **Public Relations:** _____
   _____
   _____
   _____

Name of Person Completing Form

_____ **Title** _____

(Please type or print)

Signature _____ **Date** _____